
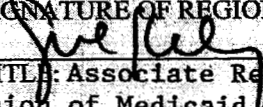


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER:  <b>04-04</b>	2. STATE  <b>New York</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>January 1, 2004</b>	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.204		7. FEDERAL BUDGET IMPACT: a. FFY 01/01/04 – 09/30/04 \$254,565 b. FFY 10/01/04 – 09/30/05 \$339,420	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B, Page 16(a)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>To replace Attachment 4.19-B, Page 16, Hyperbaric Oxygen Therapy</b>	
10. SUBJECT OF AMENDMENT: <b>Non-Institutional Services – Hyperbaric Oxygen Therapy</b>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input checked="" type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>New York State Department of Health, Corning Tower, Empire State Plaza, Room 1466, Albany, New York 12237</b>	
13. TYPED NAME: <b>Kathryn Kuhmerker</b>			
14. TITLE: <b>Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: <b>December 30, 2003</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>MAR 16 2004</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Sue Kelly</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid and State Operations</b>	
23. REMARKS:			

**OFFICIAL**

New York  
16(a)

Attachment 4.19-B  
(01/04)

**Hyperbaric Oxygen Therapy (HBOT)**

The Department of Health will continue to conduct a pilot reimbursement program for a period of three additional years to study and determine the efficacy of funding certain outpatient HBOT services provided by select hospitals in New York State.

- (a) Hospitals will be selected based upon their experience in providing outpatient HBOT services and pending appeals to establish specialty outpatient HBOT rates of reimbursement, which were submitted to the Department no later than January 25, 2000. In order to participate in the program, such hospitals will be required to submit quarterly reports to the Department that include specific measurable outcomes in order to determine the effectiveness of the program.
- (b) Outpatient HBOT services covered by Medicaid in this pilot program include only those listed in Section 35-10A of the Medicare Coverage Issues Manual published by the [Health Care Financing Administration] Centers for Medicare And Medicaid Services.
- (c) The payment rate for outpatient HBOT services provided in accordance with Section 35-10A of the Medicare Coverage Issues Manual shall be the current Medicare APC rate paid through the hospital outpatient prospective payment system.

TN 04-04 Approval Date MAR 16 2004  
Supersedes TN 01-05 Effective Date JAN 01 2004